United States Senate
WASHINGTON, DC 20510

April 14, 2017

The Honorable David Shulkin
Secretary of Veterans Affairs
810 Vermont Avenue, Northwest
Washington, DC 20240

Dear Secretary Shulkin,

We write to you today deeply disturbed by the troubling deficiencies at the Washington D.C. Veterans Affairs Medical Center (VAMC) outlined in a recent VA Office of Inspector General (OIG) Interim Status Report. It is critical that you provide immediate clarification on the status of the issues described in the Report and what steps you have taken, or will take, to remedy these deficiencies prior to the IG's final report.

The April 12, 2017 OIG Interim Status Report outlined serious deficiencies at the VAMC, citing a lack of inventory management and unclean or unsanitary storage environments for critical supplies that compromised patient safety. Additionally, it was reported that there were numerous critical open senior staff positions that have not been filled, leading the OIG to believe that it will be difficult for VA to immediately remedy these deficiencies - thus necessitating the extraordinary decision to publish the Interim Status Report. According to the Report, many of these staffing shortfalls date back to 2014 and 2015, including positions such as Chief Logistics Officer and Associate Medical Center Director. What prevented the VA from filling these positions that would have been able to oversee operations such as inventory management? We ask that you identify any legislative or resource needs that we can help remedy.

The most concerning aspect of this Report is that many of these issues may have been known by senior VHA officials, yet no remediation was made. The Report states that VA Central Office personnel were made aware in January 2017 and by March 29, 2017 there were still significant equipment and supply shortages. We are confident that any senior officials or staff that were in a position to act and yet failed to do so, will be held accountable. We urge you not to delay any accountability actions or necessary investigative steps pending the completion of the OIG's on-going investigation. In order for us to understand how VHA handled this situation initially, we ask you provide us with copies of any Issue Briefs or other communications received at VHA Central Office from the VAMC or VISN 5 and a by name and position listing of which senior VHA officials received these reports over the last year. Additionally, we ask that you explain what steps you have taken to ensure that these issues are not occurring in other VA facilities and

that you update our offices with an expected completion date for the OIG's immediate action recommendations and to inform us once they're completed.

Given the imminent safety concern justifying this interim report, we also ask for a commitment to keep us informed if you or your staff learn of any patient safety risks at the VAMC other than those identified in the interim report. To that end, we ask VA to conduct appropriate reviews to assess whether there was harm done to anyone who may have been exposed to inappropriately maintained equipment (for example, tools on the trays marked expired with Sterrad chemical strips). If you do not feel any such actions are warranted, we ask for an explanation.

Finally, these reports were initially sent to the OIG by an employee who witnessed that something unsafe and wrong was occurring and took it upon themselves to notify the proper authorities. We encourage you to recommit to ensuring all protections necessary are in place for whistleblowers and to foster an environment where employees feel comfortable coming forward when they have concerns.

Veterans throughout our home states consistently call for improving the VA health care system because the VA is where they prefer to receive their care. We appreciate the services that VA facilities provide veterans and are proud of the workers and veterans who deliver that care. However, veteran safety should never be compromised under any circumstance – particularly if due to inadequacy in basic hospital functions, such as keeping an appropriate inventory of safe and sterile supplies. If these issues do occur, we expect immediate action so that no further patients are put at risk.

We look forward to your prompt response.

Sincerely,

Tim Kaine
U.S. Senate

Jon Tester
U.S. Senate

Mark Warner
U.S. Senate